BlueCross®
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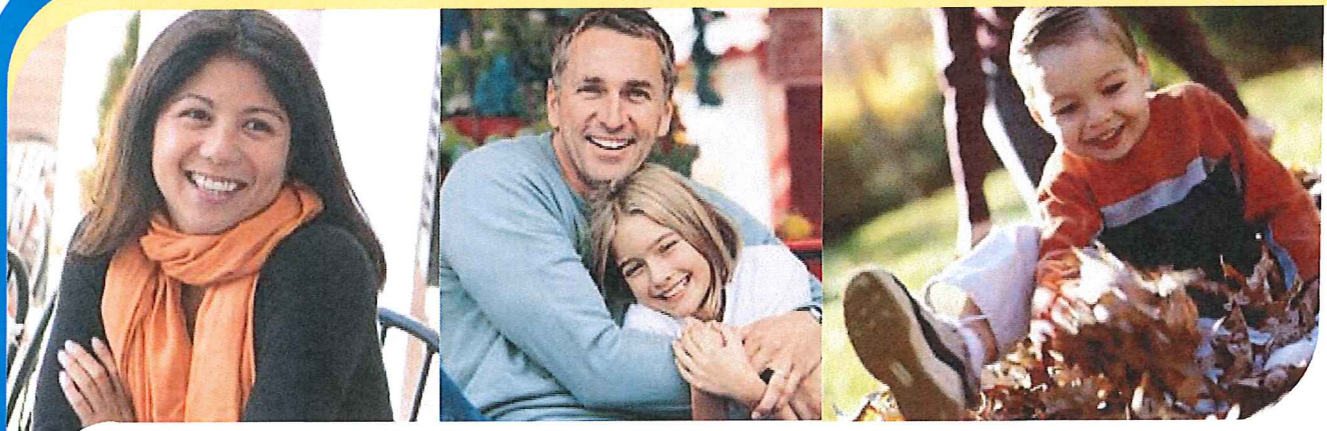

PPO Blue Options℠ v.3

Summary of Benefits

MIIA

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents effective January 1, 2011, as part of the Massachusetts Health Care Reform Law.

Your Choice

PPO Blue Options v.3 is a preferred provider organization (PPO) health plan. You have the option of selecting providers who are part of the network (preferred providers) or providers who are outside the network (non-preferred providers). You'll generally receive a higher level of benefits—and pay lower out-of-pocket costs—when you choose in-network providers.

When You Choose Preferred Providers. Within the network, certain preferred primary care physicians and preferred general hospitals are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

Where you receive care will determine your out-of-pocket costs for most services under the plan. By choosing Enhanced Benefits Tier preferred providers each time you get care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier**—Includes preferred providers in Massachusetts that met our quality benchmark and our benchmark for lowest cost.
- **Standard Benefits Tier**—Includes preferred providers in Massachusetts that met our quality benchmark and our benchmark for moderate cost. Also includes providers without sufficient data for measurement on one or both benchmarks. In limited circumstances, the Standard Benefits Tier includes certain providers whose scores would put them in the Basic Benefits Tier to provide geographic access for members.
- **Basic Benefits Tier**—Includes preferred providers in Massachusetts that scored below our quality benchmark and/or our benchmark for moderate cost.

Note: PCPs were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Providers without sufficient data for either cost or quality are placed in the Standard Benefits Tier. Providers that do not meet benchmarks for one or the both of the domains and hospitals that use nonstandard reimbursement are place in the Basic Benefits Tier.

It is important to consider the tier of both your physician and the facility where your physician has admitting privileges before you choose a preferred primary care physician or receive care. For example, if you require hospital care and your Enhanced Benefits Tier preferred primary care physician refers you to an Enhanced Benefits Tier preferred hospital, you would pay the lowest cost sharing for both your physician and hospital services. Or, if your Enhanced Benefits Tier preferred primary care physician refers you to a Basic Benefits Tier preferred hospital for care, you will pay the lowest copayments for preferred primary care physician services, but the highest copayments for hospital services, except in an emergency.

Out-of-Pocket Maximum. For in-network services, you are protected by a calendar-year out-of-pocket maximum . Only copayments for hospital admissions and ambulatory surgery admissions, will be applied to your out-of-pocket maximum. When the money you have paid equals the amounts shown below, full coverage, based on the allowed charge, will be provided for these services for the remainder of that calendar year:

- Inpatient admissions in a general hospital:
  - $600 per member for Enhanced Benefits Tier hospital admissions each calendar year
  - $1,200 per member for Standard Benefits Tier and Basic Benefits Tier hospital admissions each calendar year
- Inpatient admissions in a mental hospital or substance abuse treatment facility:
  - $600 per member each calendar year
- Outpatient day surgical admissions:
  - $300 per member each calendar year

Copayments paid for Enhanced Benefits Tier hospital admissions will apply to the out-of-pocket maximum amount for Standard Benefits Tier and Basic Benefits Tier hospital admissions and vice versa.

How to Find a Preferred Provider. There are several ways to find a preferred provider or find the tier designation of a preferred primary care physician or preferred general hospital:

- Look up a provider in your Provider Directory. If you need a copy of the directory, call Member Service at the number on your ID card.
- For Massachusetts providers, visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**.

For providers in other states, visit the BlueCard® Provider Finder website at **www.bcbs.com/healthtravel/finder.html**, or call the BlueCard Program at **1-800-810-BLUE (2583)**, 24 hours a day, seven days a week.

Note: In some out-of-state PPO service areas, different levels of preferred providers may not be available. In this case, your cost share will be the same as it would be for an Enhanced Benefits Tier preferred provider.

When You Choose Non-Preferred Providers. You must pay a calendar-year deductible for most out-of-network services. The calendar-year deductible begins on January 1 and ends on December 31 each year. The deductible is **$150** for each member (or **$300** per family). After you have met your deductible, you pay **20 percent** co-insurance for most out-of-network covered services. When the money paid for the deductible and **20 percent** co-insurance equals **$3,000** for a member in a calendar year, benefits for that member will be provided in full, based on the allowed charge, for the rest of that calendar year. **This provision does not apply to admissions in a skilled nursing facility. If you reach your out-of-pocket maximum you must still pay your co-insurance for admissions in a skilled nursing facility.** Refer to your benefit description and riders for a definition of allowed charge and how the deductible and co-insurance are calculated.

Emergency Room Services. In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a **$50** copayment per visit for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital.

Utilization Review Requirements. You must follow the requirements of Utilization Review, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Home Health Care, and Individual Case Management. Information concerning Utilization Review is detailed in your benefit description. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits. This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics	Your Cost In-Network	Your Cost Out-of-Network (after your deductible)
Plan-year deductible	None	$150 per member $300 per family
Covered Services		
Outpatient Care Emergency room visits	All Tiers: $50 per visit (waived if admitted or for observation stay)	$50 per visit, no deductible (waived if admitted or for observation stay)
Routine physical exams, including related tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life • One visit per calendar year age 2 or older	Nothing	20% co-insurance
Routine GYN exams, including related tests (one per calendar year)	Nothing	20% co-insurance
Routine vision exam (one every 24 months)	Nothing	20% co-insurance
Routine hearing exam	Nothing	20% co-insurance
Hearing supplies for one hearing aid or one set of binaural hearing aids (up to $1,700 each 24 months*)	All charges beyond the benefit maximum	All charges beyond the benefit maximum
Primary care physician visits at an office or health center	Enhanced Benefits Tier: $10 per visit Standard Benefits Tier: $15 per visit Basic Benefits Tier: $20 per visit Other covered provider: $25 per visit	20% co-insurance
Specialists and other covered provider visits	$25 per visit	20% co-insurance
Mental health and substance abuse treatment	$10 per visit	20% co-insurance
Chiropractor office visits (up to 20 visits per calendar year)	$15 per visit	20% co-insurance
Short-term rehabilitation therapy–physical and occupational (up to 60 visits per calendar year**)	$15 per visit	20% co-insurance
Speech, hearing, and language disorder treatment–speech therapy	$15 per visit	20% co-insurance
Home health care and hospice services	Nothing	20% co-insurance
Oxygen and equipment for its administration	Nothing	20% co-insurance
Prosthetic devices	Nothing	20% co-insurance
Diagnostic X-rays, lab tests, and other tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing	20% co-insurance
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing	20% co-insurance
Outpatient Surgery (and related anesthesia) Office setting	Enhanced Benefits Tier: $10 per visit Standard Benefits Tier: $15 per visit Basic Benefits Tier: $20 per visit Other covered provider: $25 per visit	20% co-insurance
Surgical day care unit of a general hospital	$100 per admission	20% co-insurance
Ambulatory surgical facility	$100 per admission	20% co-insurance

* This includes dispensing fees and acquisition costs. You pay nothing for the first **$500** of allowed charges; then 20% coinsurance up to the benefit maximum. No benefits are provided for the replacement of lost or broken hearing aids, replacement parts, or hearing aid repairs.

** No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care and for the treatment of autism spectrum disorders.

Your Medical Benefits (continued)

Covered Services	Your Cost In-Network	Your Cost Out-of-Network (after your deductible)
Inpatient Care (and maternity care) General hospital care (as many days as medically necessary)	Enhanced Benefits Tier: $200 per admission Standard Benefits Tier: $400 per admission Basic Benefits Tier: $400 per admission	20% co-insurance
Mental hospital or substance abuse facility care (as many days as medically necessary)	$200 per admission	20% co-insurance
Chronic disease hospital care (as many days as medically necessary)	$200 per admission	20% co-insurance
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% co-insurance
Skilled nursing facility care (up to 45 days per calendar year)	Nothing	20% co-insurance
Prescription Drug Benefits		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$10 for Tier 1 $20 for Tier 2 $40 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$20 for Tier 1 $40 for Tier 2 $90 for Tier 3	Not covered

Healthy Blue Programs

At Blue Cross Blue Shield of Massachusetts we offer you a group of programs, discounts and savings, resources, and tools to help you get the most you can from your health care plan. Call us at **1-800-782-3675** to receive information that outlines these special programs.

www.livinghealthybabies.com	No additional charge
A Fitness Benefit toward membership at a health club (see your benefit description for details)	$150 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year, per individual/family
Living Healthy Vision℠—discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Safe Beginnings—discounts on home safety items	Discount varies
Blue Care Line℠ to answer your health care questions 24 hours a day—call 1-888-247-BLUE (2583)	No additional charge
Living Healthy Naturally℠—discounts on different types of complementary and alternative medicine services such as acupuncture, massage therapy, nutritional counseling, personal training, Pilates, tai chi, and yoga	Up to a 30% discount
Visit www.AHealthyMe.com for an around-the-clock healthy approach to fitness, family, and fun	No additional charge

Questions? Call 1-800-782-3675.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.com**.
Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. Please Note: Blue Cross and Blue Shield of Massachusetts, Inc., administers claims payment only and does not assume financial risk for claims.

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